

FILED JAN 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2905
Registrar's No. 0096

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3726 Juniata		d. STREET ADDRESS (If rural, give location) 16 3726 Juniata	

3. NAME OF DECEASED (Type or Print) **Minnie Hoffman**

a. (First) _____ b. (Middle) _____ c. (Last) _____

4. DATE OF DEATH (Month) (Day) (Year) **Jan. 4, 1954**

5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Dec. 4, 1869	9. AGE (In years last birthday) 84	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 48 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME **John Voelker**

13b. MOTHER'S MAIDEN NAME **Unknown**

14. NAME OF HUSBAND OR WIFE **Wm. Hoffman**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) **no**

16. SOCIAL SECURITY NO. **no**

17. INFORMANT'S SIGNATURE OR NAME **Wm. Hoffman** ADDRESS **3726 Juniata**

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) **Right cerebral hemorrhage**

ANTECEDENT CAUSES DUE TO (b) **with CH Hemorrhage**

DUE TO (c) **Essential hypertension**

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH **12 hours**

19a. DATE OF OPERATION _____

19b. MAJOR FINDINGS OF OPERATION _____

20. AUTOPSY? YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? **331X**

22. I hereby certify that I attended the deceased from **May 10, 1953**, to **Jan 4, 1954**, that I last saw the deceased alive on **Jan 4, 1954**, and that death occurred at **4:35pm.**, from the causes and on the date stated above.

23a. SIGNATURE **[Signature]** (Degree or title) _____

23b. ADDRESS **3506 Hickman**

23c. DATE SIGNED **1/5/54**

24a. BURIAL, CREMATION, REMOVAL (Specify) **Burial**

24b. DATE **1-7-54**

24c. NAME OF CEMETERY OR CREMATORY **New Picker Cem.**

24d. LOCATION (City, town, or county) (State) **St. Louis, Mo.**

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE **[Signature]**

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS **SOUTHERN FUNERAL HOME 6822 S. GRAND BLVD. ST. LOUIS 11, MO.**

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. W. C. Weinsberg,
3606 Gravois
Si 2959
Gr. 6080

2 to 4

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

.....
working under my personal supervision.

..... Student Embalmer No.

Student
Student Embalmer

Signed *David M. Fosson,*

Licensed Embalmer No. *4342*

P. O. Address *6322 So Grand*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.